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Annual Survey of Virginia Law: Health Care Law

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HEALTH CARE LAW

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I. OVERVIEW AND INTRODUCTION

Health care law has proven to be a fertile ground for both legislative and judicial activity. The field covers a wide range of legal concerns including regulatory issues such as the Virginia Certificate of Public Need laws, hospital licensure statutes, antitrust issues as they relate to the activities of physicians, hospitals and other health care related institutions, as well as basic issues of contract and tort law.¹ The recent year witnessed substantial legislative and judicial changes. This article discusses these changes as they affect hospitals, physicians and other participants in the health care industry in the Commonwealth of Virginia.

II. CONSENT TO MEDICAL AND PSYCHIATRIC TREATMENT

All patients have the right to accept or decline medical treatment based on their individual assessments of the risks and consequences of the proposed treatment and the alternatives available.² For many years, it has been a common practice for hospitals, phy-

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1. Developments in the areas of medical malpractice and antitrust are specifically dealt with in other portions of this Annual Survey of Virginia Law. See Stone, *Medical Malpractice: Annual Survey of Virginia Law*, 23 U. RICH. L. REV. 741 (1989); Urbanski, *Antitrust: Annual Survey of Virginia Law*, 23 U. RICH. L. REV. 455 (1989).

2. Under the doctrine of informed consent, a physician has an affirmative duty to advise the patient of the nature of the proposed treatment, its inherent risks, alternatives to such treatment and the probability of success. *Dessi v. United States*, 489 F. Supp. 722, 727 (E.D. Va. 1980) (applying Virginia law); *Bly v. Rhoads*, 216 Va. 645, 648, 222 S.E.2d 783, 787 (1976). Courts have held that a physician's failure to obtain the consent of a patient gives rise to an action for battery. See *Pugsley v. Privette*, 220 Va. 892, 263 S.E.2d 69 (1980). More frequently, courts have viewed the physician's duty of full disclosure as a fundamental aspect of medical treatment and have held that a physician's failure to obtain informed consent is a type of medical malpractice subject to the standards governing negligence actions. See *Cunningham v. United States*, 683 F.2d 847 (4th Cir. 1982) (applying Virginia law); *Bly v. Rhoads*, 216 Va. 645, 222 S.E.2d 783 (1976).

sicians and health care providers to accept the consent of the spouse or other next-of-kin on behalf of a patient³ who, because of his physical or mental condition, is unable to provide informed consent. However, no statute or judicial decision had expressly approved substitute decision making by family members as a general means of satisfying the informed consent requirement.⁴ In the 1988-89 Session, the General Assembly enacted several significant statutes intended to create a more comprehensive framework for substitute decision making and to address specific issues relating to the use of antipsychotic drugs and electroconvulsive therapy. In addition, the General Assembly passed a number of statutes establishing and defining the informed consent requirements in testing for the human immunodeficiency virus ("HIV") and the reporting and release of such test results.⁵

A. *Substitute Consent to Treatment*

Newly enacted section 37.1-134.4 of the Code of Virginia (the "Code")⁶ creates a statutory "safe harbor" for physicians and health care facilities who rely on family members and other specified persons to make treatment decisions on behalf of patients incapable of making an informed decision regarding treatment.⁷ The statute, which applies only to adult patients,⁸ generally covers the providing, withholding and withdrawing of medical treatment, but does not apply to nontherapeutic sterilization, abortion or psycho-

3. Unless otherwise indicated, all references to a "patient" in this article shall mean a patient over eighteen years of age.

4. *But see* VA. CODE ANN. §§ 54.1-2981 to -2992 (Repl. Vol. 1988 & Cum. Supp. 1989) (authorizing specified family members to consent to the withholding or withdrawing of treatment of an incompetent patient suffering from a "terminal condition").

5. All statutes discussed in this article became effective July 1, 1989, except VA. CODE ANN. § 32.1-37.2 (Cum. Supp. 1989), discussed *infra* note 73-81 and accompanying text which became effective October 1, 1989.

6. VA. CODE ANN. § 37.1-134.4 (Cum. Supp. 1989).

7. *Id.* § 37.1-134.4(B). The statute defines the term "incapable of making an informed decision" as "unable to understand the nature, extent or probable consequences of a proposed medical decision, or unable to make a rational evaluation of the risks and benefits of the proposed decision as compared with the risks and benefits of alternatives to that decision." Persons who are deaf, dysphasic or have other communication disorders, but who are otherwise mentally competent and able to communicate by means other than speech, are excluded from this definition. *See id.*

8. Except in the case of an emancipated minor, a parent or legal guardian of a minor patient must give informed consent to medical treatment of the minor. If a parent or guardian is unavailable, consent to treatment of minor patients is governed by the detailed guidelines set out in VA. CODE ANN. § 54.1-2969 (Repl. Vol. 1988).

surgery.⁹ It may not be used to authorize admission to a mental retardation facility or psychiatric hospital.¹⁰ However, once a patient has otherwise been properly admitted to a mental retardation facility or psychiatric hospital, the statute may be employed to authorize a specific treatment or course of treatment.¹¹

Section 37.1-134.4 of the Code is cumulative with existing law. Thus, it does not affect the availability of the Virginia Natural Death Act,¹² existing statutes regarding judicial consent to treatment¹³ or other procedures relating to the providing, withholding or withdrawing of treatment.¹⁴ Also, the statute does not diminish any common law authority of a physician to provide, withhold or withdraw treatment of a patient unable to make an informed decision.¹⁵

To rely on section 37.1-134.4 of the Code, a licensed physician must determine, based on a personal examination of the patient, that the patient is incapable of making an informed decision about his medical treatment. The patient's incapacity can be due to mental illness, mental retardation or other mental disorder, or because of a physical disorder which precludes communication or impairs judgment.¹⁶ Prior to treatment, this evaluation must be separately certified in writing by another physician or clinical psychologist who has examined the patient and who is not otherwise currently involved in the treatment of the patient.¹⁷

9. Specific statutory procedures governing substitute consent to nontherapeutic sterilization and abortion insure that the rights of the patient are adequately protected. *See id.* §§ 18.2-76, 54.1-2974 to -2980. No statute presently exists authorizing substitute consent to psychosurgery.

10. This is governed by the provisions of VA. CODE ANN. §§ 37.1-67.1 to -67.3 (Cum. Supp. 1989) (involuntary admission to mental health facility) and *id.* § 37.1-65.1 (Repl. Vol. 1984) (involuntary admission to a mental retardation facility).

11. *Id.* § 37.1-134.4(C).

12. *Id.* §§ 54.1-2981 to -2992 (Repl. Vol. 1988 & Cum. Supp. 1989).

13. *Id.* § 37.1-134.5 (Cum. Supp. 1989); *see infra* note 32-57 and accompanying text.

14. *E.g., id.* § 32.1-57 (Cum. Supp. 1989) (court ordered testing for venereal disease); *id.* § 54.1-2970 (medical treatment of incompetent patients in state psychiatric hospitals); *id.* § 37.1-235 (Repl. Vol. 1988) (informed consent by subject in human research); *id.* § 54.1-2976 (sterilization of adults incapable of informed consent).

15. *See, e.g.,* *Canterbury v. Spence*, 464 F.2d 772, 788-89 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972) (consent implied in law in emergency situations); *Rogers v. Lumbermens Mut. Casualty Co.*, 119 So. 2d 649 (La. 1960) (excused absence of informed consent based on physician's therapeutic privilege to withhold disclosure of risks if such disclosure would be detrimental to the patient's health); *O'Brien v. Cunard S.S. Co.*, 154 Mass. 278, 28 N.E. 266 (1891) (consent implied from the circumstances).

16. VA. CODE ANN. § 37.1-134.4(B) (Cum. Supp. 1989).

17. *Id.* § 37.1-134.4(E).

Once a determination of incapacity has been made and confirmed, the physician, if he complies with all other terms of the statute, may provide, withhold or withdraw a specific treatment or course of treatment upon the authorization of one of certain designated representatives of the patient, in the following order of priority: (i) any person designated in a writing executed pursuant to the Virginia Natural Death Act, if given such authority in the writing;¹⁸ (ii) a guardian or committee currently authorized to make such decisions;¹⁹ (iii) an attorney-in-fact appointed under a durable power of attorney that grants the specific authority to make such a decision,²⁰ provided that the attorney-in-fact is not employed by the physician or the organization employing the physician; (iv) the patient's spouse; (v) an adult son or daughter of the patient; (vi) a parent of the patient; (vii) an adult brother or sister of the patient; or (viii) any other relative of the patient in descending order of blood relationship.²¹

Prior to providing treatment in reliance on such authorization, the statute requires the physician to satisfy three conditions. First, the physician must take reasonable steps to insure that the person providing the consent is the highest available person in the order of priority.²² Second, if the physician intends to rely on a power-of-attorney, he must make a reasonable effort to contact the patient's next-of-kin, if known, to ascertain whether there is any ground for questioning the apparent authority conferred by the power-of-attorney.²³ Finally, the physician must make a reasonable inquiry to determine whether the proposed treatment would have been "pro-

18. See *id.* §§ 54.1-2981 to -2992 (Repl. Vol. 1988 & Cum. Supp. 1989). A person designated to act for a patient in a declaration in the form recommended by the Virginia Natural Death Act may make treatment decisions on behalf of the patient only after the patient has been diagnosed as suffering from a "terminal condition" within the meaning of § 54.1-2982. *Id.* § 54.1-2982 (Repl. Vol. 1988). In order for a Natural Death Act designee to make medical treatment decisions under section 37.1-134.4 on behalf of a patient who is incapable of making an informed decision, but who is not suffering from a "terminal condition," it appears that the form of Natural Death Act declaration must be broader than that set forth in the statute.

19. See *id.* §§ 37.1-128.01 to -147 (Repl. Vol. 1984 & Cum. Supp. 1989).

20. See *id.* § 11-9.1 (Repl. Vol. 1989).

21. *Id.* § 37.1-134.4(B) (Cum. Supp. 1989).

22. Only the person in the highest order of priority may make treatment decisions on behalf of the patient. Thus, if the physician reasonably determines that the patient's spouse is in the highest order of priority available, only the spouse would be authorized to provide substitute consent under the statute, and the physician could not rely on the consent of an adult son or daughter or other relative of the patient in providing treatment. *Id.*

23. *Id.*; accord *id.* §§ 11-9.2, -9.4 (Repl. Vol. 1989).

tested" by the patient if the patient was competent.²⁴

The first two conditions arguably can be satisfied by reference to relatively objective information available to the physician. The third condition is more problematic. Under section 37.1-134.4 of the Code, a physician may not provide any treatment that he believes the patient would protest. Similarly, the statute prohibits the patient's representative from authorizing treatment that he knows, or upon reasonable inquiry should know, is contrary to the religious beliefs or "basic values" of the patient.²⁵ These provisions apparently were intended to address situations such as those involving persons whose religious practices prohibit blood transfusions or other specific types of medical treatment.²⁶ The broad language of the statute, however, gives rise to difficult questions of interpretation. The extent of the duty of inquiry placed upon the physician and the representative of the patient is unclear. Moreover, the statute does not define the terms "basic values" or "protested."

If all of the requirements of the statute have been satisfied, treatment may be initiated in reliance on section 37.1-134.4 of the Code. To continue the treatment, the physician must, at least every 180 days, obtain written certification by an independent physician or clinical psychologist that the patient continues to be incapable of making an informed decision regarding treatment.²⁷

Section 37.1-134.4 of the Code expressly provides that no person or facility providing, withholding or withdrawing treatment pursuant to an authorization obtained under its provisions will be subject to liability arising out of a claim of lack of consent or authorization.²⁸ The immunity, however, is not, by its terms, as broad as that provided by similar statutes. Unlike the immunity provisions in, for example, the Virginia Natural Death Act,²⁹ section 37.1-134.4 does not provide that good faith or substantial compliance with the statute is sufficient to confer immunity. Accordingly, the immunity created by section 37.1-134.4 of the Code may be available only if the physician strictly complies with every requirement

24. *Id.* § 37.1-134.4(D) (Cum. Supp. 1989).

25. *Id.*

26. See Note, *Their Life is in Their Blood: Jehovah's Witnesses, Blood Transfusions and the Courts*, 10 N. KY. L. REV. 281 (1983).

27. VA. CODE ANN. § 37.1-134.4(E) (Cum. Supp. 1989).

28. *Id.* § 37.1-134.4(G).

29. VA. CODE ANN. §§ 54.1-2988 to -92 (Repl. Vol. 1988 & Cum. Supp. 1989).

of the statute. Further, compliance with the statute does not expressly create immunity from criminal prosecution³⁰ or a charge of unprofessional conduct under the licensure statutes.³¹

The statute creates an administratively complex framework for substitute decision making. This complexity is compounded by troublesome ambiguities in the definition of the respective duties of the physician and the patient's representative to seek and evaluate evidence of the patient's subjective wishes regarding treatment. Even with its difficulties, however, section 37.1-134.4 of the Code should give health care providers additional comfort and guidance in relying on substitute decision making. Attempted compliance with the statute does not act as an exclusive election, in that a party who inadvertently fails to satisfy one of the requirements of the statute may still rely on the common law to justify his actions. Therefore, the health care provider is not placed at any additional risk in attempting to follow the procedures of section 37.1-134.4.

B. *Judicial Authorization of Treatment*

In situations in which specific statutory or common law procedures for substitute consent are unavailable or uncertain, health care providers may turn to the courts to authorize treatment. Historically, however, unless the patient met the criteria for involuntary commitment for psychiatric treatment under section 37.1-67.1 of the Code,³² the courts were only empowered to order specific treatment of a physical condition. This left hospitals and physicians with no clear means of treating many patients suffering from the less extreme and debilitating psychiatric disorders.

In response to this problem, the General Assembly amended the statute governing judicial consent to treatment and emergency de-

30. *E.g.*, *id.* § 18.2-36 (Repl. Vol. 1988) (involuntary manslaughter); *id.* § 18.2-57 (assault and battery).

31. *Id.* § 54.1-2914 (Repl. Vol. 1988 & Cum. Supp. 1989).

32. *Id.* § 37.1-67.3 (Cum. Supp. 1989). A court may order involuntary commitment only upon a finding that (i) the person presents an imminent danger to himself or others as a result of mental illness, or (ii) has been proven to be so seriously mentally ill as to be substantially unable to care for himself, and (iii) that there is no less restrictive alternative to institutional confinement and treatment and that the alternatives to involuntary hospitalization were investigated and were deemed unsuitable. Under this procedure, a person who meets criteria (i) or (ii), but who does not need voluntary confinement and treatment as specified under criteria (iii), may, as an alternative to institutional treatment and confinement, be ordered to participate in outpatient treatment, day or night treatment in a hospital, or other appropriate treatment modalities. *Id.*

tention of incompetent patients.³³ The amended statute, section 37.1-134.5 of the Code,³⁴ substantially expands the courts' power to order emergency and long-term treatment of patients unable to make an informed decision regarding medical care.

The amendments permit any circuit court judge, general district court judge, juvenile and domestic relations court judge, or a special justice³⁵ to authorize, on behalf of an adult patient, a specific treatment or course of treatment for a mental or physical disorder if clear and convincing evidence demonstrates that (i) there is no legally authorized guardian or committee available, (ii) the patient is incapable of making an informed decision on his own behalf, (iii) the patient is unlikely to become capable of making an informed decision within the time required for decision, and (iv) the proposed treatment is in the patient's best interests.³⁶ The court may not order any treatment if it is proven by a preponderance of evidence that such treatment is contrary to the patient's religious beliefs or "basic values," unless such treatment is necessary to prevent death or a serious irreversible condition.³⁷ Like the general substitute consent statute, section 37.1-134.5 of the Code cannot be used to authorize nontherapeutic sterilization, abortion or psychosurgery or admission to a mental retardation facility or psychiatric hospital.³⁸ In addition, the statute prohibits a court from authorizing restraint or transportation of a patient, unless it is shown by clear and convincing evidence that restraint or transportation is necessary for an authorized treatment of a physical disorder.³⁹

One area that has been particularly wrought with uncertainty is

33. *Id.* § 37.1-134.2 (Repl. Vol. 1988) (amended by *id.* § 37.1-134.5 (Cum. Supp. 1989)).

34. *Id.* § 37.1-134.5 (Cum. Supp. 1989).

35. *See id.* § 37.1-88 (Repl. Vol. 1984).

36. *Id.* § 37.1-134.5(A), (G) (Cum. Supp. 1989). The statute appears to contemplate the availability of judicial consent even if the patient has relatives who could consent pursuant to section 37.1-134.4, discussed *supra* notes 6-31 and accompanying text. Query whether courts may decline to act where substitute consent of a family member may be readily obtainable?

37. *Id.* § 37.1-134.5(G)(4). Thus, if a physician is unable to treat an incompetent patient under section 37.1-134.4 because there is reason to believe that such treatment is contrary to the religious beliefs or "basic values" of the patient, the physician could turn to the courts to authorize treatment under section 37.1-134.5, if the treatment is necessary to prevent death or a serious irreversible condition.

38. *Id.* § 37.1-134.5(H).

39. Restraint or transportation of a patient who is found to present a danger to himself or others because of mental illness may be authorized by the court under the temporary detention and involuntary commitment procedures. *See id.* § 37.1-71 (Cum. Supp. 1988).

the authority of a court to order electroconvulsive therapy⁴⁰ or antipsychotic medication⁴¹ for involuntarily committed patients who object to such treatment.⁴² This uncertainty has centered in large part on the due process requirements that must be satisfied before a state can override an involuntarily committed patient's refusal and forcibly medicate or treat such patient.⁴³ Newly enacted sec-

40. Electroconvulsive therapy ("ECT") involves the use of electrically induced seizures to treat severe depression. Potential side effects of the procedure include brain damage, broken bones and long or short-term memory loss.

41. The term "antipsychotic medication" refers to medicines such as Thorazine, Mellaril, Prolixin and Haldol, which are used in the treatment of psychoses, particularly schizophrenia. Antipsychotic medications have a number of serious side effects, foremost among which is tardive dyskinesia, an irreversible neurological disorder characterized by involuntary movements such as sucking and smacking of the lips, lateral jaw movements and darting of the tongue. When tardive dyskinesia becomes permanent, there is no known effective treatment. See Smith & Simon, *Tardive Dyskinesia Revisited: A Major Health Crisis*, 31 MED. TRIAL TECH. Q. 342 (1985).

42. Courts generally have recognized the right of a competent involuntary mental patient to make his own treatment decisions. See *Rogers v. Okin*, 634 F.2d 650, 657 (1st Cir. 1980); cf. VA. CODE ANN. § 37.1-87 (Repl. Vol. 1984) (the admission of a person to a psychiatric hospital does not, of itself, create a presumption of legal incapacity or incompetency). Because of the potentially deleterious side effects of ECT and antipsychotic medication, many courts also have recognized the right of an incompetent involuntary mental patient to refuse those treatments. These courts have viewed the mind-altering nature of antipsychotic medication and ECT and the severe side effects of these treatments as implicating the patient's first amendment guarantees of freedom of thought and communication and the constitutional rights of privacy. See *Bee v. Greaves*, 744 F.2d 1387 (10th Cir. 1984); *Rennie v. Klein*, 653 F.2d 836, 842-46 (3d Cir. 1981) (en banc), *vacated*, 458 U.S. 1119 (1982); *Davis v. Hubbard*, 506 F. Supp. 915 (N.D. Ohio 1980). The right of an involuntary mental patient to refuse treatment is qualified by the state's *parens patriae* interests in protecting the patient and its police power to protect its citizens. See Hermann, *The Basis for the Right of a Committed Patient to Refuse Psychotropic Medication*, 22 J. HEALTH & HOSP. L. 176 (1989); Comment, *An Involuntary Mental Patient's Right to Refuse Treatment with Antipsychotic Drugs: A Reassessment*, 48 OHIO ST. L.J. 1135 (1987); Comment, *Psychiatry with a Conscience: A Survey of the Right to Control Psychotropic Medication and the Involuntary Committed Mental Patient*, 54 TENN. L. REV. 85 (1986).

43. Virginia Department of Mental Health, Mental Retardation and Substance Abuse Service's regulations set out certain due process rights of patients subject to hazardous treatment or irreversible surgical procedures in facilities licensed by the Department. See VA. CODE ANN. § 37.1-84.1 (Cum. Supp. 1989). These regulations provide that no patient shall be subject to such treatment or procedures without his prior informed consent or that of his legally authorized representative and require that the patient or the patient's representative be given an opportunity for further consultation and/or impartial review of such proposed treatment or surgery by at least one medical specialist. VIRGINIA DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION, RULES AND REGULATIONS TO ASSURE THE RIGHT OF PATIENTS IN PSYCHIATRIC HOSPITALS AND OTHER PSYCHIATRIC FACILITIES (1980); see also *United States v. Charters*, 863 F.2d 302 (4th Cir. 1988) (en banc) (vacating 829 F.2d 479 (4th Cir. 1987)) (due process in ordering forced administration of antipsychotic drugs is satisfied when "the base-line decision [is] committed to medical professionals, subject to review for arbitrariness"); *Johnson v. Silvers*, 742 F.2d 823 (4th Cir. 1984) (due process in the forcible administration of antipsychotic drugs to an involuntarily committed patient re-

tion 37.1-134.5 of the Code expressly confirms the courts' authority to order administration of antipsychotic medication and electroconvulsive therapy and defines the scope of and evidentiary basis for the courts' exercise of such authority.⁴⁴

Section 37.1-134.5 of the Code provides that a court can authorize the administration of antipsychotic medication to an incompetent patient for a period of up to 180 days or electroconvulsive therapy for a period of up to sixty days. Such treatments may be ordered over the objection of an involuntarily committed patient, but not over the objection of a voluntarily committed patient. Prior to authorizing electroconvulsive therapy, however, the court must find by clear and convincing evidence that all other reasonable forms of treatment have been considered and that such treatment is the most effective treatment for the patient.⁴⁵ The evidence must include testimony of a licensed psychiatrist. Although no similar finding must be made prior to ordering administration of antipsychotic medication,⁴⁶ the statute seeks to protect the patient from the harmful effects of long-term treatment by requiring that the court order authorizing the administration of such medication require the physician to review and document the appropriateness of its continued use at least every thirty days.⁴⁷

As under the prior statute, a request for judicial authorization is initiated by a petition, filed by the health care provider or by another interested party, with the circuit court or judge of the city or county where the allegedly incompetent person resides or is located or in the city or county where the proposed place of treatment is located.⁴⁸ A certified copy of the petition must be sent to the patient and, if known, to the patient's next-of-kin. An attorney will be appointed by the court to protect the interests of the patient.⁴⁹

quires only that the courts "make certain that professional judgment in fact was exercised" in rendering such treatment).

44. VA. CODE ANN. § 37.1-134.5 (Cum. Supp. 1989). The General Assembly also adopted a parallel statute, relating to medical and psychiatric treatment of prisoners sentenced and committed to the Department of Corrections. *Id.* § 53.1-40.1; *see also id.* §§ 53.1-40.2 to -40.8 (involuntary admission of mentally ill prisoners).

45. *Id.* § 37.1-134.5(H)(3).

46. *Id.*

47. *Id.* § 37.1-134.5(I).

48. *Id.* § 37.1-134.5(C).

49. Appointment is not required if the patient, or other interested person on behalf of the patient, elects to retain private counsel at his own expense to represent the interests of the patient at the hearing. If the allegedly incapable person is indigent, his counsel may be paid

Following the appointment of an attorney, the court must schedule an expedited hearing and provide notice of such hearing to interested parties. Evidence presented at the hearing may be submitted by affidavit in the absence of objection by any interested party. The patient's attorney has the obligation to investigate the risks and benefits of and alternatives to the proposed treatment. The attorney also must make a reasonable effort to inform the patient of this and ascertain the patient's religious beliefs, "basic values," and the views and preferences of the patient's next-of-kin.⁵⁰

An order authorizing treatment under section 37.1-134.5 of the Code may be oral or written,⁵¹ and must require the treating physician to report to the court any change in the patient's condition resulting in probable restoration of the patient's capacity prior to the completion of the authorized treatment. The physician also may be required to report to the court any change in the patient's circumstances which may indicate that the authorized treatment is no longer in the patient's best interests.⁵²

When an incapacitated patient requires more immediate treatment of a physical or mental condition, section 37.1-134.5(L) of the Code retains the procedure for obtaining judicial authorization of emergency detention and treatment previously available under former section 37.1-134.2(F) of the Code. However, the new statute greatly expands the practical availability of the emergency detention procedure.

Under the previous statute, an emergency detention order could be obtained to hold an incapacitated adult patient in a hospital emergency room for up to twelve hours only in order to treat a physical injury or illness which requires testing, observation or treatment within that period to prevent death, disability or a serious irreversible condition.⁵³ The limited reach of the statute created a number of problems. First, emergency detention for testing, observation or treatment of a mental condition was not available.

by the Commonwealth of Virginia from funds appropriated to reimburse expenses incurred in the involuntary commitment process. *Id.* § 37.1-134.5(D); *see id.* § 37.1-89.

50. *Id.* § 37.1-134.5(C)-(F).

51. *Id.* § 37.1-134.5(I). Any order of a judge may be appealed *de novo* within ten days to the circuit court of the jurisdiction where the order was entered, and any order of a circuit court, whether entered originally or on appeal, may be appealed within ten days to the court of appeals. *Id.* § 37.1-134.5(J).

52. *Id.* § 37.1-134.5(I).

53. *Id.* § 37.1-134.2(F) (Cum. Supp. 1987) (amended by *id.* § 37.1-134.5(L) (Cum. Supp. 1989)).

This left health care providers with the difficult choice of either treating the patient and risking an action for false imprisonment, battery or lack of informed consent, or releasing the patient without treatment and risking an action for injury or death of the patient resulting from their failure to provide needed treatment.

Second, the previous statute authorized detention only in hospital emergency rooms.⁵⁴ This made the procedure unavailable to a large number of health care facilities and clinics to which incapacitated patients in need of treatment presented themselves.

Newly enacted section 37.1-134.5(L) of the Code⁵⁵ expands and modifies the emergency detention provisions to address these deficiencies. An emergency detention order may now be obtained to hold a patient for up to twenty-four hours for treatment of a mental and/or physical condition if the standard of care calls for testing, observation or treatment of the condition within the next twenty-four hours to prevent death, disability or a serious irreversible condition. Further, the statute makes it clear that emergency detention orders are available not only to hospital emergency rooms, but also to other "appropriate health care facilities."⁵⁶ Accordingly, drug and alcohol treatment centers, psychiatric hospitals and similar facilities can now utilize emergency detention to hold individuals in need of emergency medical or psychiatric treatment or observation, but who do not meet the standards for temporary detention under section 37.1-67.1 of the Code.⁵⁷

These amendments should enhance the ability of the courts to respond to the health care needs of incapacitated patients when substitute consent is unavailable or uncertain. In particular, the guidelines established for courts and judges ordering administration of electroconvulsive therapy and antipsychotic medication should alleviate much of the earlier uncertainty faced by courts and health care providers.

54. *Id.*

55. *Id.* § 37.1-134.5(L) (Cum. Supp. 1989).

56. *Id.*

57. A temporary detention order ("TDO") may be obtained to hold any person who is a danger to himself or others or who is substantially unable to care for himself as a result of mental illness and is unable or unwilling to seek treatment. Such order allows the patient to be held in an appropriate facility for a period not to exceed 48 hours (72 hours on weekends and holidays). Under a TDO, only emergency medical and psychiatric services may be authorized. A TDO is usually the first step in an involuntary commitment. *See id.* §§ 37.1-67.1 to -67.3.

III. HIV TESTING AND REPORTING

The 1988-89 General Assembly also adopted several significant statutes relating to the diagnosis and treatment of the human immunodeficiency virus.⁵⁸ This new legislation addresses numerous issues relating to public health and the rights and responsibilities of patients and health care providers, including physician reporting, sexual contact tracing, informed consent to HIV testing and confidentiality of test results.⁵⁹

A. Confidentiality of HIV Test Results

Newly enacted section 32.1-36.1 of the Code expressly provides that the results of every HIV test are confidential.⁶⁰ The statute, however, specifies the following persons to whom HIV test results may be released without breach of the confidentiality requirements: (i) the subject of the test or his legally authorized representative; (ii) any person designated in a release signed by the subject or his legally authorized representative; (iii) the Department of Health; (iv) health care providers for purposes of consultation or providing care and treatment to the subject; (v) health care facility staff committees that monitor, evaluate or review programs or services; (vi) medical or epidemiological researchers for use as statistical data only; (vii) any person allowed access to such information by a court order; (viii) any facility which procures, processes, distributes or uses blood, other bodily fluids, tissues or organs; (ix) any person authorized by law to receive such information; (x) the parents of the subject if the subject is a minor; and (xi) the spouse of the subject.⁶¹ Any person who willfully or through gross negligence makes an unauthorized disclosure may be subject to a civil penalty of up to \$5,000 per violation.⁶² In addition, the subject of the unauthorized disclosure may sue to recover the greater of actual damages or \$100, and may be awarded reasonable attorneys' fees and court costs.⁶³

58. For a comprehensive description of the human immunodeficiency virus and its epidemiology, see 54 Fed. Reg. 23,042 (1989) (proposed OSHA rule to reduce occupational exposure to bloodborne pathogens) (proposed May 30, 1989).

59. The General Assembly also passed legislation requiring the development of model guidelines for school attendance by children infected with HIV, the establishment of educational programs for students at Virginia public colleges and universities, the creation of regional AIDS resource and consultation centers, and the establishment of anonymous testing sites for HIV. See VA. CODE ANN. §§ 22.1-271.3, 23-9.2:3.2, 32.1-11.2, 32.1-55.1.

60. VA. CODE ANN. § 32.1-36.1 (Cum. Supp. 1989).

61. *Id.* § 32.1-36.1(A)(1)-(11).

62. *Id.* § 32.1-36.1(B).

63. *Id.* § 32.1-36.1(C).

The language authorizing release of HIV test results to the persons designated in the statute is permissive. The statute does not specify the situations in which a health care provider may be compelled to release HIV test results. As a practical matter, however, the list of parties to whom the information may be released includes, with the exception of the spouse of the patient or the parent of a minor patient, agencies or individuals who need the information for patient or public health purposes or who otherwise have an established legal right to such information. The inclusion of the spouse or parent on this list is at best problematic, since these individuals may not otherwise have a right to patient test information without the patient's consent.⁶⁴

Although section 32.1-36.1 of the Code delineates the persons to whom the physician may release HIV test results,⁶⁵ section 32.1-36 of the Code clarifies that there is no duty on the part of a physician to do so and provides that no cause of action can arise from the physician's failure to notify any other third party.⁶⁶

Thus, section 32.1-36.1 of the Code does not, by its terms, create any enforceable right to HIV test results in the designated persons. It could be argued, however, that a designated person has standing to petition a court to order a provider to release HIV test results. It is not clear, however, what evidence of need a court would require of such a petitioner or whether and under what circumstances a provider could be sanctioned for refusing to provide HIV test results to a designated person.⁶⁷

B. *Physician Reporting Requirements*

Amended section 32.1-36 of the Code requires a physician to report to the local health department the identity of any patient who has tested HIV positive.⁶⁸ This creates a statutory exception to the

64. See *id.* § 8.01-413(B) (Repl. Vol. 1984). Parental consent is not required for a minor patient to obtain an HIV test. See *id.* § 54.1-2969(D)(1) (Repl. Vol. 1988) (a minor shall be deemed an adult for purposes of consenting to medical services needed to determine the presence of any infectious disease reportable to the State Board of Health).

65. See *supra* notes 60-64 and accompanying text.

66. VA. CODE ANN. § 32.1-36(C) (Cum. Supp. 1989).

67. See *Id.* § 32.1-36.

68. VA. CODE ANN. § 32.1-36(C) (Cum. Supp. 1989).

confidentiality provisions of section 32.1-36.1 of the Code.⁶⁹

Upon receiving a report, the health department may undertake sexual contact tracing in accordance with regulations to be promulgated by the State Board of Health.⁷⁰ It is not known how far-reaching the Board's tracing program will be. The proposed regulations promulgated by the Board make it clear that the Board intends to make contact tracing mandatory.⁷¹ The proposed regulations, however, do not provide for a judicial or administrative mechanism to compel patient disclosure of sexual contacts.⁷²

C. *Informed Consent to HIV Testing*

Newly enacted section 32.1-37.2 of the Code⁷³ requires health care providers to obtain the informed consent of the patient prior to performing a test for HIV. In addition, the patient must have an opportunity for individual, face-to-face disclosure of the test results and appropriate counseling regarding the meaning of the test results, the need for additional tests, the etiology, prevention and effects of AIDS, the availability of appropriate medical and mental health care and social services, the need to notify any sexual contacts and the availability of assistance through the Department of Health in notifying such individuals⁷⁴ and other matters which may be of concern to the patient.

By requiring specific informed consent to HIV testing, the statute makes it clear that a general consent to treatment and testing cannot be relied upon to authorize an HIV test.⁷⁵ This will require health care providers to adopt more formal procedures for documenting informed consent and assuring the patient an opportunity for appropriate counseling.

69. Previously, physician reporting of HIV infection was permissive, except when the physician required the health department's assistance with patient and contact counseling and epidemiological tracking. *See id.*; Virginia State Board of Health, Emergency Regulations for Disease Reporting and Control VR 355-23-01 (1987).

70. VA. CODE ANN. § 32.1-39 (Cum. Supp. 1989).

71. *See* Virginia State Board of Health, Regulations for Disease Reporting and Control, VR 355-28-01.02 (Proposed Sept. 25, 1989).

72. *See, e.g., id.* § 32.1-57 (creating a mandatory system for examination, testing and treatment of persons suspected of being infected with venereal disease).

73. VA. CODE ANN. § 32.1-37.2 (Cum. Supp. 1989).

74. *See supra* notes 68-72 and accompanying text.

75. An argument frequently made by hospitals is that by consenting to treatment, the patient implicitly consents to the withdrawal of blood samples for diagnostic testing and, therefore, implicitly consents to an HIV test. *E.g.,* *Plowman v. United States Dep't of Army*, 698 F. Supp. 627, 629 (E.D. Va. 1988).

The informed consent requirement of section 32.1-37.2 of the Code is qualified by new mandatory implied consent provisions contained in section 32.1-45.1 of the Code.⁷⁶ To protect health care workers conducting high risk procedures, this statute provides that, if any health care provider is directly exposed to the body fluids of a patient in a manner which, according to the current guidelines of the Center for Disease Control ("CDC"),⁷⁷ may transmit HIV, the patient will be deemed to have consented to an HIV test and to the release of such test results to the person who suffered the exposure.⁷⁸ The health care provider must tell the patient about such implied consent prior to providing the patient with health care services that create a risk of exposure.⁷⁹ Accordingly, hospitals and physicians must determine, by reference to current CDC guidelines, the procedures that would create a risk of exposure and include a disclosure of the implied consent provision in the informed consent process.

Recognizing a need also to protect a patient who suffers a risk of exposure from contact with body fluids of a health care provider, new section 32.1-45.1 of the Code contains an almost identical implied consent requirement applicable to the health care provider.⁸⁰ Under this provision, a surgeon who cuts himself during surgery and bleeds into the operative site could be required to undergo an HIV test and share the test results with the patient. There is no requirement, however, that the patient be advised of this provision.

Although the implied consent procedures established in section 32.1-45.1 of the Code will provide health care workers suffering a high risk exposure an assurance of patient cooperation in addressing that risk, the extent to which the statute will protect patients who suffer the same exposure is unclear. Patients often will not be aware of the risk of a particular exposure or, as in the case of an exposure during surgery, of the exposure itself. Because the statute does not require that the patient be advised that the health care provider's consent may be implied, the patient may not be aware

76. VA. CODE ANN. § 32.1-45.1 (Cum. Supp. 1989).

77. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, PUBLIC HEALTH SERVICE, CENTER FOR DISEASE CONTROL, RECOMMENDATIONS FOR PREVENTION OF HIV TRANSMISSION IN HEALTH CARE SETTINGS (1987) (as clarified in and supplemented by 37 MORBIDITY & MORTALITY WEEKLY REPORT 377 (1988)).

78. VA. CODE ANN. § 32.1-45.1(A).

79. *Id.*

80. *Id.* § 32.1-45.1(B).

of his right to compel the health care provider to submit to an HIV test. Thus, in many situations, the benefits to the patients of section 32.1-45.1 of the Code in large part will depend on the quality of the information shared with the patient by health care providers.

IV. HOSPITAL MEDICAL STAFF ISSUES

The principal case law developments during the preceding year involved hospital medical staff privilege issues and the operation of complimentary medical services by hospitals and their affiliates.⁸¹ The majority, however, arose in the staff privileges context.

The denial, limitation or revocation of hospital admitting privileges has spawned more litigation in the health care field than perhaps any other activity.⁸² The privilege to admit and treat patients is critical to the economic survival of most physicians and many allied health care professionals.⁸³ The supply of physicians continues to expand beyond demand⁸⁴ and third-party reimbursement practices have continued to apply pressure to reduce physician fees. The importance of hospital staff privileges, and therefore the incentive to judicially challenge any decision adversely affecting such rights, has continued to increase.

Such challenges are typically grounded in federal and state anti-trust laws, but often include claims under federal anti-discrimination statutes, as well as state law claims of defamation, breach of contract and interference with contractual relationships. Several of such challenges have recently resulted in decisions by the Court of Appeals of the Fourth Circuit and federal district courts in Virginia which addressed issues of first impression and helped to clarify certain aspects of the physician/hospital relationship.

81. The majority of these decisions involved alleged violations of federal and state anti-trust laws. For a discussion of the antitrust aspects of such cases, see Urbanski, *Antitrust Law: Annual Survey of Virginia Law*, 23 U. RICH. L. REV. 455 (1989).

82. A 1985 survey by the National Health Lawyers Association (2,500 members) identified 36 pending challenges to medical staff privileges decisions, which constituted the majority of the health law antitrust cases then reported.

83. The term "allied health care professional" includes professionals licensed to provide services without physician supervision such as chiropractors, podiatrists and oral surgeons, as well as those providing care under the direction or supervision of a physician such as nurse anesthetists, nurse practitioners and physician's assistant. See generally VA. CODE ANN. §§ 54.1-2929 to -2941 (Repl. Vol. 1988) (licensure of physicians, podiatrists and chiropractors); *id.* §§ 54.1-2942 to -2957.3 (Repl. Vol. 1988) (licensure of other practitioners).

84. See Bowman, *Estimates of Physician Requirements for 1990*, 250 J. AM. MED. A. 2523, 2623, 2624, 2626 (1983).

A. Discrimination Claims

Two companion cases filed by husband and wife physicians of East Indian origin, *Mahendra S. Shah v. Memorial Hospital*⁸⁵ and *Purnima M. Shah v. Memorial Hospital*,⁸⁶ dealt with numerous aspects of hospital privileging decisions, including claims of discrimination under 42 U.S.C. § 1981⁸⁷ on the basis of race and national origin. Mahendra Shah, a urologist, and Purnima Shah, an anesthesiologist, applied for privileges at The Memorial Hospital in Danville, Virginia. Although each ultimately received provisional privileges, they alleged that their applications were improperly delayed, that attempts were made to limit their privileges and that competing physicians interfered with their patient referral relationships.⁸⁸

The United States District Court for the Western District of Virginia dismissed the *Purnima Shah* action on defendants' motion for summary judgment.⁸⁹ Although dismissing the claims under 42 U.S.C. § 1981 in the *Mahendra Shah* action, the court denied summary judgment on the other claims.⁹⁰ The Fourth Circuit recently affirmed, *per curiam*, the district court's decision in *Purnima Shah*.⁹¹

In *Purnima Shah*, plaintiff alleged that Danville Anesthesiologist, Inc. ("DA"), the only anesthesiology group practice in Danville, Virginia, and the hospital initially conspired to stall approval of her application for medical staff privileges.⁹² Upon finally being

85. 1988-2 Trade Cas. (CCH) ¶ 68,199 (1988).

86. *Id.* ¶ 68,198.

87. All persons within the jurisdiction of the United States shall have the same right . . . to make and enforce contracts, to sue, be parties, give evidence, and to have the full and equal benefit of all laws and proceedings for the security of persons and property as is enjoyed by white citizens

42 U.S.C. § 1981 (1982).

88. In each case, the plaintiff sued the hospital, individual hospital administrators and most local physicians practicing the same specialty, alleging a conspiracy to restrain the practice of their specialty to monopolize the particular specialty practice in violation of the Sherman Act. See 15 U.S.C. §§ 1, 2 (1982). Plaintiffs also asserted claims under the Virginia Antitrust Act and common law claims of tortious interference with contractual and business relationships. See VA. CODE ANN. §§ 59.1-9.1 to -9.18 (Repl. Vol. 1987).

89. 1988-2 Trade Cas. (CCH) ¶ 68,198 (1988).

90. *Id.* ¶ 68,199.

91. *Shah v. Memorial Hosp.*, 875 F.2d 316 (4th Cir. 1989).

92. *Shah*, 1988-2 Trade Cas. (CCH) ¶ 68,198 at 59,321. It has been generally held that

awarded provisional privileges, she was employed by DA on a part-time basis. At the conclusion of her provisional year, plaintiff requested full-time employment. She was again offered only a part-time position and therefore resigned. However, plaintiff alleged that shortly thereafter, DA employed a white male anesthesiologist on a full-time basis. Further, in reviewing her performance in connection with her application for advancement to active staff privileges, DA members recommended that limitations be placed on the types of anesthesia that plaintiff could practice. In reliance on such recommendation, the hospital restricted her privileges. Finally, she contended that the various physician defendants pressured other physicians not to refer patients to her.⁹³

The court found no evidence that the defendants were motivated by racial discrimination.⁹⁴ Plaintiff's evidence consisted of an alleged disparity between the handling of her application and that of a Filipino physician, on the one hand, and the application of the white male later employed by DA. The court noted that "three cases are hardly a statistically representative sample from which [to] . . . infer racial discrimination."⁹⁵ More importantly, the court found that the defendants had submitted logical reasons other than racial bias for their actions. As the plaintiff had been foreign trained, the court acknowledged that it would logically take longer to process her application, especially where she was unknown to anyone on the hospital's medical staff.⁹⁶ Further, the Credentials Committee of the Medical Staff had noted the plaintiff's failed attempts to obtain board certification⁹⁷ and had expressed concern over a gap in her experience in open heart surgery and pulmonary

physicians have no absolute right to practice medicine in a private hospital. Instead, practice privileges are subject to the discretion of the governing body of the hospital. *Thompson v. Wise Gen. Hosp.*, 707 F. Supp. 849, 853 (W.D. Va. 1989) (citing *Medical Center Hosp. v. Terzis*, 235 Va. 443, 446, 367 S.E.2d 728, 730 (1988)); *Khoury v. Community Medical Hosp.*, 203 Va. 236, 245, 123 S.E.2d 533, 539 (1962). Pursuant to the standards of the Joint Commission on Accreditation of Health Care Organizations, accredited facilities must establish a procedure whereby physicians apply for medical staff membership and hospital specific practice privileges. JOINT COMMISSION ON ACCREDITATION OF HEALTH CARE ORGANIZATIONS, 1989 ACCREDITATION MANUAL FOR HOSPITALS, Standards MS1-MS7 at 101-23.

93. *Shah*, 1988-2 Trade Cas. (CCH) ¶ 68,198 at 59,321.

94. *Id.* at 59,322.

95. *Id.*

96. *Id.*

97. *Id.* Plaintiff had unsuccessfully attempted to pass the oral portion of the American Board of Anesthesiology examination on several occasions prior to applying for privileges. It was acknowledged by the defendants, however, that specialty board certification was not required for provisional staff privileges. *See id.*

care noted by one of her references. In light of these concerns and the lack of further evidence indicating racial bias,⁹⁸ the court found that the hospital was reasonable in taking nine months to review and investigate Shah's application. Applying *Celotex Corp. v. Catrett*⁹⁹ the court concluded that plaintiff's evidence was simply insufficient for a reasonable jury to find in her favor.¹⁰⁰

The court reached the same conclusion regarding the 42 U.S.C. § 1981 claim in the *Mahendra Shah* case, but its analysis was more detailed.¹⁰¹ Mahendra Shah had purchased the practice of a retiring urologist. He alleged that a conspiracy, directed by a local urology group practice, began as soon as he applied for hospital privileges, resulting in a delay of seven months in processing his application. Further, Shah asserted that the other urologists in the locality refused to provide him with hospital emergency room coverage, expressing doubts about his medical competence.¹⁰² Shah obtained coverage from non-urologists, but the defendants allegedly reinterpreted the hospital's medical staff bylaws to require that he be covered only by another urologist. Shah then attempted to recruit another urologist from outside Danville to become his partner. However, he alleged that his efforts were systematically thwarted by the defendants, who stalled all such applications.¹⁰³

98. The only other assertion noted by the court was the plaintiff's claim that she had overheard one of the defendant physicians express a "distaste" for foreign physicians. *Id.*

99. 477 U.S. 317 (1986).

100. 1988-2 Trade Cas. (CCH) ¶ 68,198 at 59,322. *Celotex Corp. v. Catrett*, 477 U.S. 317 (1986), involved the applicable standard upon which to assess summary judgment motions under Rule 56 of the Federal Rules of Civil Procedure. The Supreme Court held that failure of the non-moving party to make a showing sufficient to establish the existence of any element essential to such party's cause of action, and upon which such party would bear the burden of proof at trial, justified the grant of summary judgment. *See also* *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242 (1986).

101. The text of the case as reported in the Trade Regulations Reporter (CCH) deletes those portions of the decision not dealing with antitrust issues. Citations to the remaining portion of the opinion are therefore made to *Shah v. Memorial Hosp.*, No. 86-0063-D (W.D. Va. July 27, 1988) (mem. op.).

102. *Id.* at 2-3. Most hospitals require that each medical specialty designate a staff member to be available to provide specialty "coverage" to the emergency department. Additionally, each physician is expected to arrange for another physician to provide coverage for his own patients if the first physician is unavailable. The inability to obtain coverage can thus result in a hardship upon an individual physician.

103. *Id.* at 3. During Shah's provisional privilege, the defendants appointed preceptors to oversee his work, who generated a report challenging the quality of his care. The hospital referred the review of his cases to an outside specialist whose report indicated no reason to withhold full privileges. Yet, according to Shah, defendants nonetheless attempted to withhold full staff privileges at the end of his provisional year, but the attempt was unsuccessful and Shah was granted full active staff status in October of 1983. *Id.* at 3-4.

After initially determining Shah had stated the prerequisites for a 42 U.S.C. § 1981 action,¹⁰⁴ the court looked at Shah's evidence of racial bias and ruled that it failed to withstand defendants' motion for summary judgment. As in *Purnima Shah*, the evidence was based almost entirely on a comparison between the handling of Shah's and his would-be partners' applications, on the one hand, and the alleged "virtual automatic approval" of white physicians' applications on the other. The court rejected the comparison:

[Shah] claims his recruits were denied applications for specious reasons, and that the processing of their applications was deliberately delayed, resulting in an average of 316 days to process for non-whites, as compared to 115 days for white physicians. While this alleged disparity may be evidence of an antitrust violation, taken together with other allegations implying a conspiracy, it is not sufficient to support this discrimination claim.

Even if the finder of fact should believe that these Shah recruits were treated differently, the inference of economic motivation would be much stronger than that of racial motivation.¹⁰⁵

Consistent with its ruling in *Purnima Shah*, the court stressed that defendants had offered rational explanations for the disparity in processing times. The court again noted that Shah's potential partners were all graduates of foreign medical schools or residency programs, and were previously unknown to the hospital's medical staff.¹⁰⁶ Thus, in each case, evidence of concerns grounded in quality of care issues outweighed a claimed inference of racial bias and resulted in a finding that the plaintiff had failed to present sufficient evidence to raise a triable issue of fact.

104. 42 U.S.C. § 1981 (1982) provides two protections: the right to be free from unlawful interference with the ability to make and enforce contracts, and the right to full and equal benefit of all laws. The prerequisites for a claim of interference with the right to contract include the existence of a contractual relationship. As regards to the court's discussion of this element, see *infra* pp. 35-36. To bring an action for denial of full and equal benefit of law under § 1981, the court held that it was necessary to allege and prove state action. *Shah*, No. 86-0063-D, mem. op. at 26-27 (citing *Shaare Tefila Congregation v. Cobb*, 785 F.2d 523, 525-26 (4th Cir. 1987)), *rev'd on other grounds*, 55 U.S.L.W. 4629 (U.S. May 18, 1987) (No. 85-2156); *Mahone v. Waddel*, 564 F.2d 1018 (3d Cir. 1977), *cert. denied*, 438 U.S. 904 (1978)). Under either allegation, however, the plaintiff is required to show that he is within the class of persons protected by the statute. In this regard, the court held that Shah, as an East Indian, could claim the protection of § 1981. See *Jatoi v. Hurst-Euleless-Bedford Hosp. Auth.*, 807 F.2d 1214 (5th Cir.), *modified*, 819 F.2d 545 (5th Cir. 1987) (*per curiam*), *cert. denied*, 108 S. Ct. 709 (1988).

105. *Shah*, No. 86-0063-D, mem. op. at 27-28.

106. *Id.* at 28.

B. Contract Issues

In *Thompson v. Wise General Hospital*,¹⁰⁷ the court again addressed a 42 U.S.C. § 1981 claim in the context of termination of hospital staff privileges. Its decision turned, however, on the question of whether a contract existed between the physician and the hospital.

Thompson, a black physician, was terminated from the medical staff of three separate hospitals in Wise County, Virginia.¹⁰⁸ On defendants' motions pursuant to Rules 12(b)(1) and 12(b)(6) of the Federal Rules of Civil Procedure, the district court dismissed all of Thompson's claims.¹⁰⁹

The court concluded, as had the *Shah* court, that the equal benefits provisions of 42 U.S.C. § 1981 required a showing of state action, which could not be demonstrated by the actions of a private hospital.¹¹⁰ To assess the "right to contract" prong of the statute, the court first addressed the existence of a contract. Plaintiff asserted that he had "agreements" with the defendant hospitals to provide medical services for and at the hospitals. However, because it was not alleged that Thompson was actually a staff physician, but rather that he was a family practitioner who was merely allowed to treat his patients in the hospitals, the court concluded that "a holding that a contract would be formed by such an associ-

107. 707 F. Supp. 849 (W.D. Va. 1989).

108. *Id.* at 850. The complaint typically included counts under 42 U.S.C. § 1981 alleging interference with contractual rights, 42 U.S.C. § 1985(3) asserting a conspiracy for the purpose of depriving Thompson of equal protection of law, as well as counts under §§ 1 and 2 of the Sherman Act. *Id.*; see 15 U.S.C. §§ 1, 2 (1982).

42 U.S.C. § 1985(3) provides in relevant part, that:

[I]f two or more persons . . . conspire . . . for the purpose of depriving, either directly or indirectly, any person or class of persons of the equal protection of the laws, or of equal privileges and immunities under the laws . . . if one or more persons engaged therein do, or cause to be done, any act in furtherance of the object of such conspiracy, whereby another is injured in his person or property, or deprived of having and exercising any right or privilege of a citizen of the United States, the party so injured or deprived may have an action of the recover of damages accrued by such injury or deprivation.

42 U.S.C. § 1985(3) (1982).

109. 707 F. Supp. at 850-51.

110. *Id.* at 853. A violation of 42 U.S.C. § 1981 can be founded on either of two bases, contracts or equal benefits. See *supra* note 87. The issue before the *Thompson* court was the existence of a contract necessary to invoke the first protection, the right to make and enforce contracts.

ation would be stretching matters considerably, and would also, evidently, be contrary to common law."¹¹¹ Hence, the court held that the defendants' actions did not create a contractual arrangement and dismissed the 42 U.S.C. § 1981 claim.¹¹²

The issue of whether the grant of hospital privileges creates a contractual arrangement between the physician and the hospital has arisen in only two previous Supreme Court of Virginia decisions: *Khoury v. Community Medical Hospital, Inc.*¹¹³ and *Medical Center Hospitals v. Terzis*.¹¹⁴ In neither case, however, was the issue decided.¹¹⁵ The *Mahendra Shah* opinion also addressed the question of whether the bylaws constituted a contractual relationship in the context of a 42 U.S.C. § 1981 claim. That court reviewed only the *Khoury* case, but determined that "it strongly supported creation of a contract through staff appointment."¹¹⁶ Also relying on precedent from other jurisdictions, the court concluded that Shah's medical staff status created sufficient contractual rights upon which to base a 42 U.S.C. § 1981 challenge.¹¹⁷

The *Thompson* decision, while not rejecting the proposition that appointment to the medical staff could create contractual rights, appears to rely on the fact that the plaintiff had not specifically alleged that he had been appointed to the medical staff.¹¹⁸ Thus, the ruling is consistent with *Khoury*, where the hospital board's

111. 707 F. Supp. at 854. Further, the court stated that, "[a]t common law, absent a contractual obligation to the contrary, a physician's continued association with a private hospital was within the unfettered discretion of the hospital's administrators. Denial of staff privileges, for whatever reason or no reason at all, constituted no legal wrong." *Id.* (quoting *Guibor v. Manhattan Eye, Ear & Throat Hosp., Inc.*, 46 N.Y.2d 736, 737, 386 N.E.2d 247, 248, 413 N.Y.S.2d 638, 639 (1978))

112. *Id.*

113. 203 Va. 236, 123 S.E.2d 533 (1962).

114. 235 Va. 443, 367 S.E.2d 728 (1988).

115. In *Khoury v. Community Medical Hosp., Inc.*, 203 Va. 236, 123 S.E.2d 533 (1962), the court assumed, expressly without so holding, that a contract would have come into existence had the hospital's board actually granted the plaintiff staff privileges. However, the Board of Trustees never actually approved plaintiff's appointment. Therefore, the court held that no contract existed. *Id.*

Likewise, in *Medical Center Hosps. v. Terzis*, 235 Va. 443, 367 S.E.2d 728 (1988), the court merely assumed for the purpose of its analysis that the medical staff bylaws constituted a contract between the physician and the hospital, but held that the claim should still have been dismissed on other issues. *Id.* at 445, 447, 367 S.E.2d at 729, 730.

116. *Shah v. Memorial Hosp.*, No. 86-0063-D, mem. op. at 22-23 (W.D. Va. 1988).

117. *Id.* at 23-25; see *Pariser v. Christian Health Care Sys., Inc.*, 816 F.2d 1248 (8th Cir. 1987); *Posner v. Lankenau Hosp.*, 645 F. Supp. 1102 (E.D. Pa. 1986); *Miller v. Indiana Hosp.*, 277 Pa. Super. 370, 419 A.2d 1191 (1980).

118. *Thompson*, 707 F. Supp. at 853-54.

failure to formally appoint the plaintiff to the medical staff ended the contractual rights inquiry.¹¹⁹ However, where an actual staff appointment is made, *Mahendra Shah* would indicate that, until a contrary ruling by the Supreme Court of Virginia, some form of contractual rights, at least of a nature sufficient to sustain an argument under 42 U.S.C. § 1981, do arise.¹²⁰

Another quasi-contractual claim often asserted in staff privilege litigation is tortious interference with contractual relationships. The United States District Court for the Western District of Virginia addressed this issue in *Oksanen v. Page Memorial Hospital*.¹²¹ In a lengthy opinion, the court detailed the controversy which had arisen between Dr. Oksanen and the other members of the medical staff of the hospital. Oksanen alleged that he had become concerned over the quality of care that his patients received at the hospital, particularly care rendered by certain other physicians. He also complained of the care rendered by the nursing staff, openly criticized nurses and argued with other physicians in the presence of hospital employees, patients and visitors. The Board of Trustees of the hospital undertook an investigation which resulted in a direction to the hospital's administrator to send a letter to the medical staff discussing the problems. The letter further angered plaintiff, who indicated that he would not cooperate with any attempts to improve relations among physicians and nurses until a member of the Board personally retrieved the letter. Following further incidents, the medical staff considered corrective action against Oksanen, but refused at that time to take disciplinary action.¹²²

119. *Khoury*, 203 Va. at 242-43, 123 S.E.2d at 537.

120. The application of 42 U.S.C. § 1981 in hospital staff privilege cases may change markedly due to the recent opinion. *Peterson v. McLean Credit Union*, 57 U.S.L.W. 4705 (U.S. June 15, 1989) (No. 87-107). The Supreme Court held that § 1981 does not apply to conduct which occurs after the formation of a contract and which does not interfere with the right to enforce established contractual obligations. *Id.* at 4706. In *Peterson*, the Court considered claims of racial harassment during employment, failure to promote and ultimately termination of employment. It ruled that the first prong of § 1981 protects only the right to make and enforce contracts. However, "the right to make contracts does not extend, as a matter of either logic or semantics, to conduct . . . after the contract relation has been established." *Id.* at 4708. The guarantee of the right to enforce contracts covers only private efforts "to impede access to the courts or obstruct nonjudicial methods of adjudicating disputes about the force of binding obligations." *Id.* The right to enforce contracts was held not to extend beyond conduct which impairs the ability to enforce contracts through legal process. Therefore, restriction or termination of staff privileges, as opposed to denial, even where staff privileges are found to be of a contractual nature, may arguably fall outside the context of § 1981 unless allegations are made that acts of the defendants somehow impair the physician's right to enforce the bylaws through legal process.

121. No. 88-0166-H (W.D. Va. June 16, 1989) (mem. op.).

122. *Id.* at 5-9.

Confrontations between Oksanen and other physicians continued until the Board requested the medical staff to again consider corrective action. This resulted in the Executive Committee of the Medical Staff's recommendation to revoke Oksanen's privileges. Oksanen appealed this decision, and the hospital suspended Oksanen's privileges for approximately two and one-half months, followed by a one-year probationary period.¹²³

During the probationary period, relations between Oksanen and the staff worsened. He complained that staff physicians refused to cover for him in the hospital's emergency room. The Board again requested the Medical Staff to take corrective action and, following a hearing, a recommendation was made to revoke Oksanen's privileges. Oksanen thereafter resigned, mooted the corrective action procedure.¹²⁴

The suit alleged violations of section 1 of the Sherman Act,¹²⁵ monopolization under section 2 of the Sherman Act,¹²⁶ violations of the Virginia Antitrust Act,¹²⁷ a conspiracy to injure Oksanen's business¹²⁸ and common law interference with contractual relationships. The district court dismissed all counts on summary judgment.¹²⁹ The case has been appealed to the Fourth Circuit.

The court assumed, *arguendo*, that the medical staff bylaws did give rise to a valid contract not terminable at will.¹³⁰ The Supreme Court of Virginia has held that the prerequisite elements for a claim for tortious interference with a contract not terminable at will are: "(1) the existence of a valid contractual relationship or business expectancy; (2) knowledge of the relationship or expectancy on the part of the interferer; (3) intentional interference inducing or causing a breach or termination of the relationship or expectancy; and (4) resultant damage to the party whose relationship or expectancy is disrupted."¹³¹ Focusing on the third element,

123. *Id.* at 11-12.

124. *Id.* at 15-17.

125. 15 U.S.C. § 1 (1982).

126. *Id.* § 2.

127. VA. CODE ANN. §§ 59.1-9.1 to -9.18 (Repl. Vol. 1987 & Cum. Supp. 1989).

128. *Id.* §§ 18.2-499, -500 (Repl. Vol. 1988 & Cum. Supp. 1989).

129. *Id.* at 25.

130. *Id.* at 30.

131. *Duggin v. Adams*, 234 Va. 221, 226, 360 S.E.2d 832, 835 (1987).

the *Oksanen* court held that Oksanen had failed to show any causal relationship between the defendant's actions and his resignation. Instead, the court was convinced by the evidence that Oksanen's suspension and his later resignation from the medical staff were caused by Oksanen's own behavior.¹³²

The court also addressed the question of immunity from civil liability set out by Virginia statute for acts conducted as a part of hospital peer review.¹³³ Even in light of the undisputed evidence of heated discussions and arguments between Oksanen and the various defendant physicians, the court declined to find that the evidence supported an inference that the defendants acted in bad faith or with malicious intent. Thus, the court held that members of the medical staff would be immune from liability under Virginia law for such actions, and therefore, such acts could not satisfy the causation requirement necessary to support a claim for tortious interference with a contractual relationship.¹³⁴

C. *Evidence of Conspiracy*

A showing of a conspiracy among staff physicians or between physicians and the hospital is often a critical element in staff privilege suits. The recently decided cases have provided further guidance on the issue of the sufficiency of evidence of conspiracy. The *Shah* opinions and the *Oksanen* case, in particular, illustrate the courts' approach. In *Purnima Shah*, the court considered the issue as a part of its discussion of the antitrust claims. It noted that, based on the facts of the case, the claims under both section 1 and section 2 of the Sherman Act required proof of a conspiracy.¹³⁵

132. *Oksanen*, No. 88-0166-H, mem. op. at 31-34.

133. VA. CODE ANN. § 8.01-581:16 (Repl. Vol. 1984 & Cum. Supp. 1989). The statute provides in pertinent part that:

[e]very member of or, health care professional consultant to, any committee, board, group, commission or other entity shall be immune from civil liability for any act, decision, omission or utterance done or made in performance of his duties while serving as a member of or consultant to such committee . . . with functions primarily to review, evaluate or make recommendations on . . . (v) the competency and qualifications for professional staff privileges . . . provided further that such act, decision, omission, or utterance is not done or made in bad faith or with malicious intent.

Id.

134. *Oksanen*, No. 88-0166-H, mem. op. at 32.

135. 1988-2 Trade Cas. (CCH) ¶ 68,198 (1988). In treating the plaintiff's Sherman Act § 2 claim as also requiring a showing of conspiracy, the court appeared to take judicial notice of the fact that the defendant anesthesiologists, by the nature of their practice, could not independently monopolize the provision of anesthesiology in the alleged market, but instead,

Guided by *Matsushita Electric Industrial Co. v. Zenith Radio Corp.*,¹³⁶ the court held that in order to withstand summary judgment, a plaintiff must present evidence that tends to exclude the possibility of independent action and direct or circumstantial evidence that demonstrates a conscious commitment to a common scheme to achieve an unlawful objective.¹³⁷ The court then proceeded to balance the evidence presented by the plaintiff against evidence that the alleged delay in processing her application, the restriction of her privileges and the presence of DA members on peer review committees were reasonable actions undertaken by the hospital and the physicians in considering her application for privileges. In each instance the court found a reasonable relationship between the defendants' conduct and legitimate concerns for the operation of the hospital.¹³⁸ It noted the concern of Shah's professional peers and clearly deferred to the peer review committees' professional judgment:

This Court is not competent to judge the severity of Shah's problems or to pass on her overall competency as an anesthesiologist. In light of this documentation that at least some problems existed, I cannot find the hospital's decision to restrict her privileges was more likely motivated by a conspiracy than by a concern for patient care.¹³⁹

would require the concerted action of the hospital. *Id.* at 59,322.

136. 475 U.S. 574 (1986).

137. 1988-2 Trade Cas. (CCH) ¶ 68,198 at 59,322.

138. *Id.* at 59,322-23. The court noted that the delay in approving Shah's privileges was not unreasonable in light of her foreign training and the other specific questions raised by her resume. As regards the restriction of her privileges to adult general and spinal anesthesia, the court stated that even the plaintiff had admitted having "at least two problem cases involving pediatric anesthesia." *Id.* at 59,322. Plaintiff had maintained that neither case was serious, but the court noted that the report of a Judicial Review Committee appointed by the hospital to investigate the restrictions had indicated that other physicians believed the problems to be serious and that the plaintiff had experienced other difficulties in administering various types of anesthesia. *Id.*

139. *Id.*; see also *Thompson v. Wise Gen. Hosp.*, 707 F. Supp. 849, 853 (W.D. Va. 1989), where the court quoted with approval from *Medical Center Hosps. v. Terzis*, 235 Va. 443, 446, 367 S.E.2d 728, 730 (1988) as follows:

[W]hen the trustees of a private hospital, in their sound discretion, exclude a doctor from the use of the facilities of the hospital, the courts are without authority to nullify that discretion by injunctive process. There are no constitutional or statutory rights of the doctor, or of his patients who wish to be treated in the hospital by him, which warrant such interference.

Thompson, 707 F. Supp. at 853 (quoting *Medical Center Hosps.*, 235 Va. at 446, 367 S.E.2d at 730).

The fact that allegedly antagonistic parties had some part in processing Shah's application was likewise held insufficient to establish a conspiracy. Relying on *Cooper v. Forsyth County Hospital Authority, Inc.*,¹⁴⁰ the court ruled that mere contacts or communications or the opportunity to conspire is alone insufficient evidence from which to infer an anticompetitive conspiracy, thereby clearly placing an affirmative burden upon plaintiff to produce evidence of more than staff committee and similar meetings in order to exclude the possibility of independent action.¹⁴¹

Although the allegations and proof in *Mahendra Shah* were similar to those in *Purnima Shah*, they resulted in a denial of summary judgment on the conspiracy claims. The court again weighed the evidence of conspiracy, including the alleged "stonewalling of [Shah's] potential partners," the refusal by the defendant urologists to cover and the reinterpretation of the hospital's bylaws to require coverage by a specialist, against the quality of care reasons offered by the defendants for each of these actions.¹⁴² It noted that defendants' reasons were both plausible and pro-competitive, but it found that the scales tipped toward the plaintiff:

All of the above are plausible inferences which could be drawn from the scenarios alleged by Shah. However, the inference could also be drawn that Defendants took these actions to exclude Plaintiff from medical practice in Danville. The credibility of this latter inference is enhanced by the deposition of [the urologist from whom Shah purchased his practice] who described an attitude of exclusion and protectiveness among the urologists in Danville. Further weight is added by the affidavit testimony of [one of Shah's potential partners] in which he says he was refused application for privileges at [the Hospital] because Danville didn't need any more urologists.¹⁴³

The court distinguished the case from *White v. Rockingham Radiologists, Ltd.*¹⁴⁴ and *Cooper v. Forsyth County Hospital Authority, Inc.*¹⁴⁵ noting in particular that in *White* the evidence had

140. 789 F.2d 278 (4th Cir. 1986).

141. 1988-2 Trade Cas. (CCH) ¶ 68,198 at 59,323. On this particular issue, see *infra* notes 147-50 and accompanying text.

142. 1988-2 Trade Cas. (CCH) ¶ 68,199 (1988). This decision will be cited as *Mahendra S. Shah v. Memorial Hospital*, No. 86-0063-D (W.D. Va. July 27, 1988). See *supra* note 101.

143. *Shah*, No. 86-0063-D, mem. op. at 15-16.

144. 820 F.2d 98 (4th Cir. 1987).

145. 789 F.2d 278 (4th Cir. 1986).

established that the hospital's board had acted unilaterally in approving an exclusive contract.

By contrast, there is no single entity to whom we can assign responsibility for the actions aggrieving Shah, and there is no single clear rationale underlying them.

The implication of a conscious commitment to a common scheme is dramatically greater where Defendants are alleged to have taken several independent actions whose effect is to drive plaintiff from the marketplace.¹⁴⁶

Consistent with the *Shah* cases, the *Oksanen* court weighed asserted acts of conspiracy in their actual context and considered whether such acts were more probably the reasonable conduct of a hospital and its staff designed to enhance hospital operations or, in fact, illegal conspiracies. It dismissed some of Oksanen's proffered evidence on the basis that the actions complained of were taken only by the hospital's Board of Trustees, and were not joined in by the individual defendants who comprised the hospital's medical staff. Therefore, such acts were the acts of a single entity and not the product of a conspiracy.¹⁴⁷ More importantly, in considering the actions of the individual physicians, the court required Oksanen to produce evidence tending to exclude the possibility that such defendants were simply acting in their respective capacities as members of hospital committees when they voted to recommend the revocation of Oksanen's privileges.¹⁴⁸ While recognizing that some authority exists to suggest that a medical staff of a hospital is itself a combination of physicians such that any action taken by it satisfies the conspiracy requirements of section 1 of the Sherman Act,¹⁴⁹ the court declined to adopt this position, noting that it had been previously questioned by the Fourth Circuit in *Cooper v. Forsyth County Hospital Authority, Inc.*¹⁵⁰

146. *Shah*, No. 86-0063-D, mem. op. at 17.

147. *Oksanen v. Page Memorial Hosp.*, No. 88-0166-H, mem. op. at 20 (W.D. Va. June 16, 1989).

148. "[F]ederal courts have consistently recognized that mere contacts and communications, or the mere opportunity to conspire, by antitrust defendants is insufficient evidence from which to infer an anticompetitive conspiracy in the context of the denial of hospital privileges." *Id.* at 21 (citing *Cooper v. Forsyth County Hosp. Auth., Inc.*, 789 F.2d at 291).

149. See *Weiss v. York Hosp.*, 745 F.2d 786, 812-25 (3d Cir. 1984), cert. denied, 470 U.S. 1060 (1985).

150. See *Cooper*, 789 F.2d at 281 n.12. The *Oksanen* decision appears to be consistent with a trend placing a heavy burden on the plaintiff physician in a hospital staff privilege

In *Thompson*, the question of conspiracy arose in the context of plaintiff's claim under 42 U.S.C. § 1985(3).¹⁵¹ The complaint asserted generally that individual defendants had conspired, but it failed to set out any facts to support such a conclusion. The court, in dismissing the complaint, ruled that:

Before a claim under [§ 1985(3)] can be made out, a claim of conspiracy must be 'alleged with sufficient specificity and factual support to suggest a "meeting of the minds. . . ." Although the Amended Complaint does specifically allege that 'Defendants, with express knowledge of the action of the other Defendants, acting upon such knowledge, engaged in a concerted and conspiratorial effort to deprive Plaintiff, by reason of his race, of his livelihood,' the specific factual allegations set out in the complaint provide no support whatever for this legal conclusion. Assuming that everything happened exactly the way the complaint alleges that it did, the most that it has shown is that each hospital, apparently acting independently, terminated Dr. Thompson's privileges for problems that were someone else's fault. Notably, the termination by Wise General came 14 ½ months after the termination by St. Mary's, and Norton Community terminated Dr. Thompson's ICU privileges more than six months after that, or nearly two years after St. Mary's. A hospital, being an inanimate entity, cannot itself conspire with anyone or anything; some human agency must be involved. There is no indication in the complaint of who, when, how, or where any doctors, administrators, or other individuals connected with any of the defendants conspired to deprive Dr. Thompson of any rights or privileges. And the timetable of the terminations, spread out over two years, is hardly silent [sic] evidence of a conspiracy.¹⁵²

The *Thompson* court thus reaffirmed that in order to survive a motion to dismiss, a complaint must do more than recite conclusory legal generalizations of conspiracy. Specific facts that define the alleged conspiracy are required.¹⁵³

case to come forward with evidence to exclude the inference that hospital and individual staff physicians acted independently in the course of their duties as staff officers as opposed to acting pursuant to an unlawful agreement to restrain trade.

151. See *supra* note 108.

152. *Thompson*, 707 F. Supp. at 852 (citations omitted).

153. *Id.* For cases involving conclusory allegations, see *Seglin v. Esau*, 769 F.2d 1274, 1280 (7th Cir. 1985); *Furlong v. Long Island College Hosp.*, 710 F.2d 922, 927-28 (2d Cir. 1983); *Dunn & Mavis, Inc. v. Nu-Car Driveaway, Inc.*, 691 F.2d 241, 243 (6th Cir. 1982); *Jaffe v. Horton Memorial Hosp.*, 680 F. Supp. 125 (S.D.N.Y. 1988); *Mamakos v. Huntington Hosp.*, 653 F. Supp. 1447, 1451 (E.D.N.Y. 1987).

A consistent theme in the recent cases is the courts' willingness to seriously consider quality of care justifications offered by hospitals and physicians to explain adverse staff privilege decisions.¹⁵⁴ Where the defendant's actions are limited to the peer review context and taken within the scope of the operation of hospital peer review committees, the courts are reluctant to second-guess the medical professionals or to infer anticompetitive motives. On the other hand, where allegations are made of several independent activities engaged in by numerous defendants, and where there is no clear rationale linking all the activities to a concern for quality of care, the plaintiffs have more easily overcome summary judgment on the conspiracy issue.

C. *Defamation and Other Tort Claims*

In *Sibley v. Lutheran Hospital of Maryland, Inc.*,¹⁵⁵ the Fourth Circuit, reviewing a termination of staff privileges, addressed claims of defamation and the novel theories of negligent withholding and termination of hospital privileges and intentional deprivation of hospital privileges. The district court granted summary judgment on all counts to certain individual defendants, but denied the motion as to the defendant hospital with respect to plaintiff's tortious breach of contract claim.¹⁵⁶ The Fourth Circuit affirmed the lower court's decision, adopting that opinion as its own. However, in a lengthy concurring opinion, Judge Mernaghan discussed the issues in detail.

The district court opinion and Judge Mernaghan's concurring opinion are instructive in that they are among the relatively few analyses of defamation in the staff privileges context. Both also address claims of negligent and intentional breach of an implied contract arising out of the medical staff bylaws and the effect of release language contained in a physician's application for privileges.¹⁵⁷

154. Concerns over quality of care have been proffered to successfully counter assertions of conspiracy, as well as assertions of per se liability under the antitrust laws in staff privilege cases in other jurisdictions. See *Miller v. Indiana Hosp.*, 843 F.2d 139 (3d Cir. 1988), *cert denied*, 109 S. Ct. 178 (1988); *Friedman v. Delaware County Memorial Hosp.*, 672 F. Supp. 171 (E.D. Pa. 1987), *aff'd*, 849 F.2d 600 (3d Cir. 1988).

155. 871 F.2d 479 (4th Cir.), *aff'g*, *Sibley v. Lutheran Hosp.*, 709 F. Supp. 657 (D. Md. 1989).

156. *Id.* at 480.

157. Dr. Sibley's application stated "I hereby release from liability all representatives of the Hospital and its medical staff for their acts performed in good faith and without malice

Sibley, a resident of the District of Columbia, applied for privileges in urology and emergency medicine at the defendant hospital, which was located in Baltimore, Maryland. Concern was initially raised over Sibley's residence and its effect on his ability to attend surgery patients in the hospital. He ultimately advised the hospital that he had acquired a Baltimore residence, and the hospital approved his application for urological privileges.¹⁵⁸

During consideration of his application for privileges in emergency medicine, the individual defendant (head of the Department of Surgery) reported two incidents of questionable patient care. No representation regarding the validity of the information was made because the information was based on a report of two other physicians not present at the meeting. The Credentials Committee recommended denial of emergency room privileges and the recommendation was adopted by the Medical Staff Executive Committee.¹⁵⁹

Regarding the defamation claim, the opinions recognized two applicable privileges. The district court stressed Maryland statutes which provided that persons acting in good faith and within the jurisdiction of a medical staff review committee could not be found liable in civil actions for their conduct.¹⁶⁰ Judge Murnaghan also discussed the conditional privilege at common law recognized for communications between parties with a common interest in the subject matter.¹⁶¹ In light of these privileges, a cause of action could not lie for defamation unless there was a showing of malice. Judge Murnaghan adopted the test set forth in *New York Times v. Sullivan*,¹⁶² which requires either knowledge that the alleged defamatory statement was false or that the statement was made with reckless disregard for the truth.¹⁶³ He further noted that malice

in connection with evaluating my application and my credentials and qualifications." *Id.* at 481 (Murnaghan, J., concurring).

158. *Id.* at 480-81 (Murnaghan, J., concurring).

159. *Id.* at 481-82 (Murnaghan, J., concurring).

160. See *Sibley v. Lutheran Hosp.*, 709 F. Supp. 657 (D. Md. 1989). Virginia recognizes contains a similar immunity. See VA. CODE ANN. § 8.10-581.16 (Repl. Vol. 1984 & Cum. Supp. 1989).

161. 871 F.2d at 484 (Murnaghan J., concurring). A similar common law privilege is recognized in Virginia. For cases discussing qualified privilege see, *Great Coastal Express, Inc. v. Ellington*, 230 Va. 142, 334 S.E.2d 846 (1985); *Peoples Life Ins. Co. v. Talley*, 166 Va. 464, 186 S.E. 42 (1936); *Taylor v. Grace*, 166 Va. 138, 184 S.E. 211 (1936).

162. 376 U.S. 254 (1964).

163. *Id.* at 279-80.

must be established by clear and convincing evidence.¹⁶⁴

Relying on the progeny of *New York Times v. Sullivan*, Judge Mernaghan would require Sibley to produce sufficient evidence to permit a conclusion that the defendant, in fact, entertained serious doubts as to the truth of the statements made in order to demonstrate reckless disregard. Mere evidence of inconsistencies in the defendant's statements or the failure to check the veracity of the reports made by other physicians was considered insufficient.¹⁶⁵ Further, as the district court noted, the defendant stated that he had been told the incidents were, in fact, true.¹⁶⁶ Therefore, the district court ruled that the defendant would have been derelict in his duty to the hospital had he not reported the information.¹⁶⁷

Regarding the release, Judge Mernaghan assumed that it could lose its effect upon a showing of bad faith and malice as the release was contractual in nature. However, in the absence of such showing, the Judge indicated that the release acted as a bar to the claims of negligent withholding and intentional termination of hospital privileges.¹⁶⁸

V. THE OPERATION OF RELATED SERVICES BY HOSPITALS

Two decisions by the United States District Court for the Western District of Virginia arising out of three related cases bear directly upon the legality of a hospital's decision to engage in collateral or related business activities. In three separate actions, Advanced Health-Care Services Inc., an independent supplier of durable medical equipment ("DME"), sued Twin County Community Hospital, Radford Community Hospital and Giles Memorial

164. 871 F.2d at 484 (Murnaghan, J., concurring); *accord*, *Oberbroeckling v. Lyle*, 234 Va. 373, 362 S.E.2d 682 (1987). In the district court, plaintiff had acknowledged that he had the burden of proving that the defendant acted with knowledge of the falsity of the statements or with reckless disregard to the truth and that malice must be shown by clear and convincing evidence. 709 F. Supp. at 660.

165. 871 F.2d at 484-85 (Murnaghan, J., concurring). Judge Murnaghan went on to comment that "[i]t would have been derelict if [the individual physician defendant] had not conveyed the statements of [the chief of surgery] to the Credentials Committee, unless he actually knew them to be false." *Id.* at 485.

166. *Sibley v. Lutheran Hosp.*, 709 F. Supp. 657, 661 (D. Md. 1989).

167. *Id.*

168. 871 F.2d at 487 (Murnaghan, J., concurring). The Supreme Court of Virginia has applied, in a similar context, language in hospital staff bylaws to limit a physician's right of appeal from an adverse privileging decision. *See Medical Center Hosp. v. Terzis*, 235 Va. 443, 367 S.E.2d 728 (1988), and the discussion thereof in Gravelly, *Health Care Law: Annual Survey of Virginia Law*, 22 U. RICH. L. REV. 667, 678-83 (1988).

Hospital, each of which had established their own hospital-affiliated DME company.¹⁶⁹ Radford established its DME company as a wholly-owned subsidiary of its holding company, whereas Twin County and Giles Hospitals entered into joint venture arrangements with a third party, a co-defendant in those cases.

The court initially dismissed all three complaints on motions pursuant to Rule 12(b)(6) of the Federal Rules of Civil Procedure. Plaintiff noted its appeal in the *Radford* case, but moved the district court to reconsider the remaining two actions and to permit the filing of amended complaints. The court denied these motions on the ground that the proposed amended complaints would not cure the defects earlier noted by the court.¹⁷⁰

Plaintiff challenged the operation of the hospital-affiliated DME companies as a violation of sections 1 and 2 of the Sherman Act and section 3 of the Clayton Act.¹⁷¹ It also alleged interference with business relationships in violation of Virginia common law.

The crux of plaintiff's assertions was that each hospital, in combination with the DME company, had foreclosed completion among DME companies by (i) unduly influencing hospital patients to deal with the hospital-affiliated entity; (ii) failing to inform patients of their right to choose among competing companies; (iii) failing to inform hospital patients of the prices, services and equipment offered by competitors; and (iv) subverting the patients' right to choose among competing DME vendors.¹⁷²

In the first decision, the court held section 3 of the Clayton Act inapplicable to the facts pled.¹⁷³ Because plaintiff did not compete

169. *Advanced Health-Care Servs., Inc. v. Twin County Community Hosp.*; *Advanced Health-Care Servs., Inc. v. Giles Memorial Hosp.*; *Advanced Health-Care Servs., Inc. v. Radford Community Hosp.*, Nos. 88-0344-R, 88-0345-R, 88-0346-R (W.D. Va. Dec. 29, 1988).

170. *Advanced Health Care Servs., Inc. v. Twin County Community Hosp.*; *Advanced Health Care Servs., Inc. v. Giles Memorial Hosp.* Nos. 88-0344-R, 88-0345-R (W.D. Va. Mar. 21, 1989).

171. 15 U.S.C. §§ 1, 2, 14 (1982).

172. The Code of Virginia requires that any hospital having a financial interest in any facility providing health related outpatient services, appliances or devices shall, prior to referring patient to such type of facility, provide written notice in bold print that such service, appliances and devices may be available from other suppliers in the community. The *Advanced Health Care* cases, however, did not address this statutory requirement. VA. CODE ANN. § 32.1-125.2 (Cum. Supp. 1989).

173. The United States Code provides that it is unlawful for any person to sell or lease a commodity upon the condition, agreement or understanding that the buyer or lessor will not use or deal in the commodities of a competitor of the lessor or seller. 15 U.S.C. § 14 (1982); see *Tampa Elec. Co. v. Nashville Coal Co.*, 365 U.S. 320 (1961).

with the hospitals' DME companies in the sale of equipment to hospitals, section 3 of the Clayton Act could give plaintiff no claim arising out of wholesale sales or leases to the hospitals or to other distributors associated with them.¹⁷⁴ Further, as the complaint failed to allege that transactions between distributors and patients involved any agreement by the patient not to buy or lease equipment from the competing distributor, no claim had been asserted under section 3.¹⁷⁵

The court's analysis of the section 2 of the Sherman Act claims (monopolization or attempts to monopolize) was grounded on the proposition that plaintiff had failed to allege facts constituting predatory or unreasonable conduct on the part of the defendants.¹⁷⁶ Mere possession of monopoly power is not unlawful. Thus, the mere entry of a hospital into the DME market or the market for other related services was not enough, in itself, to constitute an antitrust violation.¹⁷⁷

The *Advanced Health-Care* cases appear applicable to any ancillary service in which a hospital may own a financial interest. Under such circumstances, the hospital is subject to criticism for channelling patients to its affiliated operation. However, the *Advanced Health-Care* opinions appear to require that a would-be plaintiff establish more than the mere operation of collateral business interests and the direction of patients to them. Some element of coercion or other predatory conduct is required to convert an otherwise legitimate business endeavor into an antitrust violation.¹⁷⁸ Conduct consistent with the proper and reasonable operation of the hospital would still appear defensible.

174. *Advanced Health Care Servs.*, Nos. 88-0344-R, 88-0345-R, 88-0346-R, mem. op. at 8-9.

175. *Id.* at 9.

176. *Id.* at 10. For full discussion of the antitrust aspects of these opinions, see Urbanski, *Antitrust Law: Annual Survey of Virginia Law*, 23 U. RICH. L. REV. 455 (1989).

177. *Advanced Health Care Servs.*, Nos. 88-0344-R, 88-0345-R, 88-0346-R, mem. op. at 10. The District Court for the Eastern District of Florida has similarly dismissed a challenge to the operation of a hospital-affiliated DME company in *Key Enters., Inc. v. Venice Hosp.*, 703 F. Supp. 1513 (M.D. Fla. 1989).

178. Careful compliance with the Virginia statutory requirements mandating notice of the hospital's financial interest would also appear to provide additional insulation from challenge. See VA. CODE ANN. § 32.1-125.2 (Cum. Supp. 1989).

VI. CERTIFICATE OF PUBLIC NEED LAW

The Virginia Certificate of Public Need ("CON") statute has been under careful study for several years, beginning with the establishment of the seventeen-member Governor's Commission on Medical Care Facilities Certificates of Public Need (the "Governor's Commission") in December of 1986 to review the CON system.¹⁷⁹ The Governor's Commission issued its report on December 1, 1987,¹⁸⁰ in which it recommended that the existing CON system be retained, but that the scope of the projects requiring CON review be narrowed. The past year has seen continued implementation of the changes suggested by the Governor's Commission.

CON laws initially were designed to provide an administrative check on the unbridled expansion of health care facilities and technology and to limit cost increases to private consumers and third-party payors such as Medicare and Medicaid. Prior to July 1, 1989, the provisions of the Code of Virginia controlling the requirements for a CON defined a "medical care facility" to include any for-profit or not-for-profit institution, whether or not licensed by the Board of Health, in which health care services were furnished for the prevention, diagnosis, or treatment of disease or injury of two or more non-related persons.¹⁸¹ The definition expressly excluded physicians' offices, which were defined by regulation to include any facility owned or operated by a group of physicians, practicing in any legal form, designed to provide fundamental medical care and which did not participate in cost-based or facility reimbursement programs through Medicare and Medicaid.¹⁸²

The statute provided that one may not commence any "project" without first obtaining a CON.¹⁸³ A "project" was defined to include any capital expenditure by or on behalf of a medical care facility which, under generally accepted accounting principles was not chargeable as an expense of operation and maintenance and which exceeded \$600,000, or such higher amount as the Board of

179. Exec. Order 31 (1986).

180. REPORT OF THE GOVERNOR'S COMMISSION ON MEDICAL CARE FACILITIES CERTIFICATE OF PUBLIC NEED (1987).

181. VA. CODE ANN. § 32.1-102.1. (Repl. Vol. 1985).

182. Rules and Regulations of the Board of Health, Commonwealth of Virginia, Virginia Medical Care Facility Certificate of Public Need, 2 Va. Regs. Reg. 702 (1985) [hereinafter CON Regs.] (effective Jan. 22, 1986).

183. VA. CODE ANN. § 32.1-102.3 (Repl. Vol. 1985).

Health may prescribe.¹⁸⁴ Pursuant to the CON Regulations, this triggering amount was raised to \$700,000.¹⁸⁵ Projects also included the acquisition, by any means, of a medical care facility if the purchase would have resulted in an expenditure in excess of \$700,000, the purchase of equipment in excess of \$400,000 and the institution of any health care service.¹⁸⁶

Where a CON is required, but not obtained, the law permits the Commissioner of Health, the Board of Health or the Attorney General to enjoin the operation of the project. In addition, the Board of Health can refuse to issue a license to such project.¹⁸⁷

As a result of recommendations of the Governor's Commission, the General Assembly enacted a one-year moratorium, ending July 1, 1989,¹⁸⁸ restricting the issuance of CONs, except under limited exemptions. The purpose of the moratorium was to permit further study of CON laws and their effect on the availability of health care services for indigent citizens.

A joint subcommittee was created to study indigent health care and the appropriate role of the CON program.¹⁸⁹ That committee's report, issued in January 1989, was, in part, the impetus for major statutory changes in the CON program.¹⁹⁰

184. *Id.* § 32.1-102.2 (Repl. 1985).

185. CON Regs., *supra* note 182, § 1.1, at 6.

186. VA. CODE ANN. § 32.1-102.1 (Rep. Vol. 1985) (amended Cum. Supp. 1989); CON Regs., *supra* note 182, § 1.1, at 6, 7.

187. VA. CODE ANN. §§ 32.1-102.8, 102.10 (Repl. Vol. 1985).

188. *Id.* § 32.1-102.3:2 (Cum. Supp. 1989).

189. S.J. Res. 99, 1988 Va. Acts 2358, substitute for S.J. Res. 99 (proposed by the House Committee on Rules on Mar. 4, 1988).

190. Among the recommendations of the Interim Report of the Joint Subcommittee on Health Care for All Virginians was the following:

We offer the following recommendations with respect to the Certificate of Public Need (COPN) program:

(1) *Hospitals* — The time has come to deregulate the hospital industry from Certificate of Public Need, with certain exceptions. Psychiatric and rehabilitation hospitals should continue under COPN regulation, and no hospital beds should be converted to nursing home beds pending completion of this study.

At the same time we believe this decision must be made in the context of a new public and private partnership to ensure the provision of hospital care to those Virginians who are unable to obtain any health insurance and whose incomes are below the poverty level.

(2) *Nursing Homes* — The moratorium on approval of new certificates of public need for nursing beds should be continued until January 1, 1991. During this period no new applications for nursing home beds should be received by the Commissioner of Health. The joint subcommittee should continue its study of the certificate of public need program during the next phase.

The main effects of the amendments to the CON statute are to reduce the number of institutions covered and to restrict the definition of the term "project" so that fewer health care activities fall within the scope of the CON requirements. Specifically deleted from the definition of "medical care facilities" were any facilities licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services and any non-hospital substance abuse residential treatment programs operated by community service boards under the Department of Mental Health, Mental Retardation and Substance Abuse Services Comprehensive Plan.¹⁹¹ Only the following specified medical care facilities are now subject to review: (i) general hospitals, (ii) sanitariums, (iii) nursing homes, (iv) intermediate care facilities, (v) extended care facilities, (vi) mental hospitals, (vii) mental retardation facilities, (viii) psychiatric hospitals and intermediate care facilities established primarily for medical psychiatric or psychological treatment, rehabilitation of alcoholics or drug addicts, (ix) specialized centers or clinics developed for the provision of outpatient ambulatory surgery, and (x) rehabilitation hospitals.¹⁹² As of July 1, 1991, general hospitals and specialized facilities providing outpatient or ambulatory surgery will no longer be included in the definition of medical care facilities subject to the CON requirements, except with respect to establishing nursing home beds in general hospitals.¹⁹³

Under the new law, the definition of a project for purposes of triggering a CON review is no longer linked to a specific expenditure level. Instead, the term covers only: (i) the establishment of a new medical care facility; (ii) an increase in the total number of beds in an existing medical care facility; (iii) a relocation of ten beds or 10% of existing beds, whichever is less, from one existing facility to another within a two-year period (except that a hospital is not required to obtain a CON for the use of 10% of its beds as nursing home beds); (iv) the introduction into an existing medical care facility of a psychiatric, medical rehabilitation or substance abuse treatment service if the facility has never provided such service within the previous twelve months.¹⁹⁴

JOINT SUBCOMMITTEE ON HEALTH CARE FOR ALL VIRGINIANS, INTERIM REPORT TO THE SENATE OF 1989 at 11-12 (1989) (S. Doc. No. 18).

191. VA. CODE ANN. § 32.1-102.1 (Repl. Vol. 1985) (amended Cum. Supp. 1989).

192. *Id.* Under the previous statute, all entities meeting the general operational requirements of the statute were included within the definition including, but not limited to, those specified. *Id.*

193. *Id.* § 32.1-102.3:3 (Cum. Supp. 1989).

194. *Id.*

Pursuant to the recommendations of the joint subcommittee, the moratorium on issuance of new CONs was extended until January 1, 1991, but only for applicants requesting an increase in the number of beds in which nursing home or extended care services are provided.¹⁹⁵

Finally, where a new clinical health service is initiated and when the purchase of new medical equipment requiring an expenditure of \$400,000 or more is contemplated by a medical care facility or physician's office, the facility is required to register the initiation of such service or the acquisition of the equipment with the Commissioner of Health.¹⁹⁶ This requirement is applicable even though a CON is not required for the initiation of the service or the acquisition of the equipment.

The new statute also requires that specialized centers or clinics for the provision of certain services, including radiation therapy, magnetic resonance imaging and open-heart surgery must register with the Commissioner of Health and provide, upon request, periodic data delineating patient volumes, morbidity and mortality and aggregate costs and charges for the services provided.¹⁹⁷

The 1989 statutory changes constitute a major revision of the CON laws and appear to remove the vast majority of health care related projects, particularly those involving the implementation of new services and technology, from the purview of the CON statute. Additional changes in the law, including the complete repeal of the CON laws, continue to be considered.¹⁹⁸

195. *Id.* § 32.1-102.3:2. However, the Commissioner of Health has the flexibility to approve CONs for a project for the renovation or replacement, on site, of an existing nursing home or extended care service when the capital expenditure is required to comply with life safety codes, licensure certification or accreditation standards. The Commissioner may also approve CONs for on-site conversion of existing licensed beds to beds certified for skilled nursing services when (i) the total number of beds to be converted does not exceed the lesser of twenty beds or ten percent of the beds of the facility; (ii) the facility has demonstrated that skilled nursing beds are needed to serve certain patients, such as ventilator dependant and AIDS patients, and that such patients otherwise will not have reasonable access to such services in existing facilities; and (iii) where the facility commits to admit such patients on a priority basis once the skilled nursing unit is certified and operational. *Id.*

196. VA. CODE ANN. § 32.1-102.3:4 (Cum. Supp. 1989).

197. *Id.* Pursuant to this same provision, the Commissioner of Health is permitted to expand the services required to be registered.

198. Pursuant to Senate Bill 762, the Secretary of Health and Human Resources is re-

VII. MEDICAL CARE FOR INDIGENT PATIENTS

Closely tied to the recommended changes in the CON law were concerns regarding the availability of health care to indigent Virginia citizens. This concern, in part, resulted in the enactment of the Virginia Indigent Health Care Trust Fund.¹⁹⁹ The new legislation creates a mechanism whereby state funds and funds contributed by certain hospitals will be pooled and utilized to reimburse the costs of health care for indigent citizens. The Virginia Board of Medical Assistance Services and the Department of Medical Assistant Services are charged with maintaining the fund. The Board is authorized to promulgate rules and regulations for its administration, which are to include uniform eligibility criteria to define medically indigent persons, specific definitions of hospital inpatient and outpatient services qualifying for reimbursement, a mechanism to insure that hospitals are compensated from the fund only for charity care, and the terms and conditions of the reporting requirements imposed upon hospitals participating in the fund.²⁰⁰

The Board is also required to annually appoint a technical advisory panel to recommend policies and procedures for administering the fund, including methodologies relating to the creation of charity care standards and eligibility and service verification. The panel will also recommend contribution rates and distribution payments.²⁰¹ The panel consists of seven members, including the Chairman of the Board of Medical Assistance Services, the Director of the Department of Medical Assistance Services, the Executive Director of the Virginia Health Services Cost Review Council, two additional members of the Board of Medical Assistance Services and two chief executive officers of hospitals as nominated by the Virginia Hospital Association.²⁰²

quired to report by November 1, 1990, to the Committee on Health, Welfare and Institutions of the House of Delegates, the Committee on Education and Health of the Senate and the Joint Subcommittee on Health Care for all Virginians on the implications and effect of the repeal of the CON laws on the accessibility, affordability and quality of health care within the Commonwealth. Part of the Secretary's mandate is to report an analysis of the effects of removal of certain medical care facilities, clinics and medical technology from the CON laws, as well as the effect of deregulation on health care price competition, the affordability of primary, acute and long-term care and the budget of the Commonwealth.

199. VA. CODE ANN. §§ 32.1-332 to -342 (Cum. Supp. 1989).

200. *Id.* § 32.1-333. "Charity care" is defined as hospital care for which no payment is received and which is provided to any person whose gross annual family income is equal to or less than 100% of the Federal Non-Farm Poverty Level as published for the then-current year in the Code of Federal Regulations. *Id.* § 32.1-332.

201. *Id.* at 32.1-340.

202. *Id.* § 32.1-335.

Contributions to the trust fund by Virginia hospitals are mandatory and are based upon the amount of charity care rendered by each hospital compared to the average amount of charity care rendered by all hospitals within the Commonwealth. The law requires hospitals to file a statement of charity care and such other data as may be required by the regulations of the department no later than ninety days following the end of each hospital's fiscal year.²⁰³ A charity care percentage for each hospital is then calculated by dividing the hospital's total charity care charges by total gross revenues. The median of all charity care percentages for Virginia hospitals is used as the standard against which each hospital's charity care is tested.²⁰⁴

The Board calculates a "disproportionate share level" which constitutes a percentage figure, not to exceed 3% above the median of charity percentages.²⁰⁵ Through a formula specified in the Code,²⁰⁶ an annual contribution rate and dollar amount are then calculated for each hospital based, in part, on the hospital's operating margin and state corporate taxes paid.

A ceiling on the annual contribution rate of 6.25% of the hospital's operating margin is fixed by the statute. Those hospitals rendering charity care in excess of the state standard generally would not be required to pay any contribution amount, whereas those hospitals falling below the standard would be required to contribute to the trust fund.²⁰⁷

Distributions from the fund are made to hospitals providing a disproportionate amount of charity care, again based upon a formula involving the hospital's charity care percentage, gross patient revenues and cost-to-charge ratio. Each hospital whose charity care percentage is above the state standard, but below the disproportionate share level is paid from hospital contributions. That portion of a hospital's charity care percentage that is above the disproportionate share level is paid solely from appropriations to the fund by the General Assembly.²⁰⁸ Contributions are made once

203. *Id.* § 32.1-336.

204. *Id.* § 32.1-337.

205. *Id.*

206. *Id.*

207. *See id.* § 32.1-337.

208. *Id.* § 32.1-338.

annually in December of each calendar year, beginning in December 1990.²⁰⁹

Failure to comply with the provisions of the statute, including knowing or willful false statements or representations of material fact made in order to participate in or receive monies from the fund, knowing or willful failure to provide reports as required, or knowing or willful failure to make required payments in a timely manner, are deemed a Class I misdemeanor. Conviction of such misdemeanor also results in forfeiture of any payments due to the health care provider from the fund.²¹⁰ It would appear that the statute contemplates that employees or officers of hospitals may be personally liable for criminal penalties, as the provision specifically refers to conviction of such parties.²¹¹

Creation of the fund follows an unsuccessful attempt during the 1987-88 General Assembly to impose an initial license fee on hospitals and nursing homes, as well as a license renewal fee, proceeds of which would be placed in a special fund to pay for indigent care. The initiative failed for lack of support.²¹²

In addition to the Virginia Indigent Health Care Trust Fund, the General Assembly amended the State/Local Hospitalization Program to make participation by cities and counties mandatory.²¹³ The program is also administered by the Department of Medical Assistance Services. Funds are allocated by the director of the department annually to cities and counties based on population. The director is required to promulgate regulations setting forth the amount, duration and scope of the services provided by the program which are required to be uniform for all localities.²¹⁴ However, reimbursement for medical services is limited only to inpatient and outpatient hospital services and the services provided by freestanding ambulatory surgical centers and local public health clinics. Further, the provider must have signed an agreement to participate in the State/Local Hospitalization Program. Covered services are limited in amount, duration and scope to those available to recipients of Medicaid and as provided in the

209. *Id.*

210. *Id.* § 32.1-341.

211. *Id.*

212. See Gravely, *Health Care Law: Annual Survey of Virginia Law*, 22 U. RICH. L. REV. 667, 668-69 (1988).

213. VA. CODE ANN. § 32.1-343 to -350 (Cum. Supp. 1989).

214. *Id.* § 32.1-346.

State Plan for Medical Assistance.²¹⁵ Reimbursement is at the same rate as that provided for similar services under the Virginia Medical Assistance Program, and acceptance of payment for services under the program by a provider constitutes acknowledgment of payment in full, such that no balance billing is available.²¹⁶

Both of the foregoing changes constitute further legislative efforts to solve steps problems disclosed by the Governor's Commission and the Joint Subcommittee. Upon the promulgation of the regulations for the operation of both the Indigent Health Care Trust Fund and the State/Local Medical Assistance Program, hospitals and other health care entities will no doubt have a more definite view of the effect of these activities on their hospital operations. Continuing legislative adjustments and changes in these programs and the possible adoption of additional measures to address the indigent health care situation in Virginia is anticipated in light of the ongoing study by the Governor's Commission and the General Assembly.

VIII. CONCLUSION

The recent year has been an important one in terms of both legislative and judicial developments in the health law field. Many questions, however, remain unanswered, and legislative and case law developments have raised new issues to be confronted by the health care industry. It appears that the dynamic and changing nature of health care law will continue for the foreseeable future in the Commonwealth of Virginia.

215. *Id.* § 32.1-346. As regards statutory provision for the State Plan for Medical Assistance, see *id.* §§ 32.1-323 to -330 (1985 & Cum. Supp. 1989).

216. *Id.* § 32.1-346 (Cum. Supp. 1989).